STATE OF IDAHO

FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

SECTION IV

IDAHO STATE PLAN IMPLEMENTATION REPORT

ADULT AND CHILDREN'S MENTAL HEALTH

Fiscal Year 2003

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SECTION IV IMPLEMENTATION REPORT AND SECTION V STATE LEVEL DATA REPORTING CHECKLIST
FY2003 CMH BLOCK GRANT PLAN

TABLE OF CONTENTS

SUMMARY OF ACCOMPLISHMENTS AND NEEDS FOR CHILDREN AND ADULT COMMUNITY MENTAL HEALTH SERVICES FOR FY 2003

The most comprehensive and credible assessment of our system's current accomplishments and needs can be found in the State Planning Council on Mental Health's "Annual Report to the Governor, 2003." This report, required as part of Executive Order 98-06, which establishes the Council and defines its responsibilities, was approved by the Council at their April 2003 meeting and subsequently submitted to Governor Dirk Kempthorne in June, 2003. It is reproduced below in its entirety:

Idaho State Planning Council on Mental Health
Annual Report to the Governor
June 2003

The State Planning Council on Mental Health, pursuant to Executive Order #98-06, is pleased to submit to you our 2003 annual status report on state funded mental health services to Idaho adults and children and their families. We urge your continued leadership on behalf of adults with serious mental illness and children with serious emotional disturbance, especially because we do not see this leadership coming from the Legislature. In particular, we need adequate funding for effective, evidence based treatment for both children and adults.

We are pleased to acknowledge several accomplishments that are moving our mental health system in a positive direction:

- We appreciate your continued support for the Idaho Council on Children's Mental Health (ICCHM) which is chaired by Lt. Governor Risch. Through the efforts of the ICCMH, there are 31 local councils and 7 regional councils established throughout the state. All of these councils are working on interagency coordination, family involvement and improving services to children and families at the local and state levels.

- We applaud the Department of Health and Welfare's application for and receipt of a Federal Cooperative Agreement aimed at developing and improving the current efforts under way in children's mental health. The ICCMH is functioning as the governance body for the Federal Cooperative Agreement for the development of systems of care for Idaho's children and families. The project will increase the amount of information and data regarding services provided and support training to optimize the function of Regional and Local Councils.

- We commend Mrs. Kempthorne for her ongoing support of the Red Flags Program, the Suicide Prevention Conference, the Real Choices anti-stigma campaign and the Respite Care Project. These programs have resulted in greater

public awareness of mental health issues.

- We acknowledge the adjustment in the gravely disabled definitions within the Idaho Civil Commitment Code which paves the way for more timely treatment for persons with serious mental illnesses.

In addition to these significant accomplishments, we wish to acknowledge, on a state level, the following activities:

- Training for law enforcement regarding mental health issues.
- Telehealth activities that increase access to mental health services.
- Efforts by the Suicide Prevention Action Network and statewide community members to develop a statewide suicide prevention plan.
- The development of a mental health court in District VII.
- Reinstatement of some adult dental services in Medicaid.
- Availability of drug settlement funds to purchase high cost psychotropic medications for uninsured consumers.

CHALLENGES

Unfortunately, some of the notable accomplishments listed above pale in comparison to the many challenges Idaho continues to face. We are listing the most important challenges below in the hope that you will give the support of your office in addressing them:

- The population of the state continues to grow, yet resources for publicly funded mental health services have been reduced. Funding affects the amount of community based services and impacts at the personal level the individuals in need of recovery and treatment. We endorse full funding and staffing of Assertive Community Teams throughout the state as a method of reducing hospitalization and maintaining individuals in their communities.

- Quality assurance of publicly funded mental health services that includes knowledgeable, educated, involved consumers, provider participation, focus of services on recovery and outcomes and timely implementation of sanctions when needed is not yet in place in Idaho. We strongly recommend the direct involvement of family members and consumers in the development and monitoring of performance standards and service outcomes. More specifically, we recommend that an automated solution be developed to provide consumers with timely information about the services and benefits they receive. This would assist consumers to become more active in monitoring the services they receive as well understanding the cost of those services.

- More opportunities are needed for consumer and family member input and participation in the development of coordinated, effective mental health services. We urge the Department to identify and provide increased opportunities for consumers and family members to serve on policy and program development workgroups.

- After nearly 100 years of existence, State Hospital North is still not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We strongly advise the Department to pursue JCAHO accreditation of State Hospital North as a demonstration of the state's commitment to quality mental health care.
- Currently, a large disparity exists in benefits provided by insurers for mental health services when compared to other health related services. We recommend the adoption of policies that would assure parity for consumers and families accessing needed mental health services through private insurers.

- Idaho would benefit from the expansion of mental health courts that are supported by strong community based treatment and services. We support mental health courts as a humane method of treating individuals within their communities and reducing recidivism.

- We continue to be concerned with the state's position of opposing the Jeff D lawsuit. Although additional funds and staff have been added in the last several years, there has also been a reduction in staff this past year. Despite twenty-three years of litigation, Idaho has still not fully implemented needed children's mental health services. We strongly endorse full implementation of the court plan.

- We consider the suspension of the Medicaid peer support waiver, the closing of the LAMP Program, failure to fund the Medicaid Buy-In Program and lack of funding for peer-to-peer education to be lost opportunities to improve services for individuals and families affected by mental illness in Idaho.

- The federal Performance Partnership Block grant for mental health services requires that Idaho establish a comprehensive, community based service for persons with serious mental illness. This includes access to healthcare, including dental services. We recommend full reinstatement of Medicaid adult dental services.

- Data collection continues to be an important issue. Although progress has been made, we urge the Department of Health and Welfare to continue to dedicate resources to achieve the timeline for statewide outcomes data reporting for the Mental Health Performance Partnership Block Grant.

We thank you for this opportunity to provide you with our perspective on the mental health system in Idaho. As always, we extend an invitation to you or one of your staff

members to join us at our meetings. Our next meeting is scheduled for August 6-7, 2003, Boise Holiday Inn Airport.

Respectfully submitted,

STATE PLANNING COUNCIL ON MENTAL HEALTH

Rick Huber
Chair

dp

NEW DEVELOPMENTS AND ISSUES DURING FY 2003

1. State Economy and Budget Reductions.

Idaho, like much of the nation, suffered a lagging state economy and lower than expected state revenues during SFY 2002 and 2003. As a result, all state agencies were subject to a series of budget holdbacks totaling a cumulative 6% over the two years. The SFY 2004 budget did not include any increases for Division of Family and Community Services programs. These budget reductions are permanent, and cuts that have been made are not expected to be replaced in the future. Indeed, further cuts may be necessary.

2. Care Management for Adults with Developmental Disabilities

Health and Welfare has implemented a process called "care management" for adults with developmental disabilities. It is intended to provide Medicaid clients more choices in their care, provide them with quality services, and through this process, better control the state's growing Medicaid costs. Care management will allow for the delivery of better, more efficient, and cost-effective services to customers right in their communities. The plan consists of an independent assessment provider to identify needs and authorize services, a quality improvement plan to evaluate and improve the service delivery process and implementation of care management techniques to review how well services are actually delivered to our clients.

The Department conducted a pilot managed care program in Region 2 in SFY 2002, and is now moving ahead with implementation of a statewide program for adults with developmental disabilities. Implementation has required combining some Adult DD ACCESS Unit staff with Regional Medicaid Services staff, contracting with an independent assessment provider (IAP) and prior authorizing all adult DD services. The new business process began October 1, 2003. The implementation of care management services for adult mental health is still being evaluated.

3. Any Door initiative

The Any Door Initiative evolved out of The Idaho Department of Health and Welfare's Goal 5 to identify and recommend solutions for opportunities to align structures, people and technology while improving communication and customer service in support of the desired outcomes of all other goals. The vision of the initiative is that "Any Door" leads to healthy people, stable families, and safe children. The Mission is to improve client outcomes through the design and implementation of an integrated service delivery system. System design is scheduled to be completed by the fall of 2003 with a pilot project ready for testing by January 2004. The initiatives goals are to:

- Create a service delivery system that ensures accountability, consistency and efficiency.
- Create a service delivery system that provides comprehensive services to help client reach their goals and transition to natural supports.
- Create a client-driven and outcome-based service system.
- Create a common enrollment process to provide easier access for clients.
- Create a single integrated case plan for families that contains an specialized service or treatment plans developed with the family.
- Integrate population-based services into the new service delivery system.

4. State Mental Health Data Infrastructure Grant

In June 2001 the state submitted an application to SAMHSA and was awarded a three-year State Mental Health Data Infrastructure Grant (Mental Health Statistics Improvement Program). This grant would enable the state to build the infrastructure needed to report all of the required data elements soon to be required for the Federal Community Mental Health Block Grant Plan. In addition, it will provide the state with the information it needs to better manage its services, as well as to be more accountable to the legislature and to its other stakeholders.

A Steering Committee and Operations Team monitor and coordinate the Data Infrastructure Grant (DIG) project. DIG became part of a larger project to integrate Developmental Disabilities and Mental Health (DD/MH) data collection into the existing Family Oriented Community User System (FOCUS) used by Children and Family Services. This larger DD/MH Integration project was delayed by the issuance of an RFP for system development. In order to assure collection of MHSIP data by October, 2003, the Department pursued a contingency plan which modified a currently-existing regional mental health data system. This interim system was implemented October 1. A process will be developed to convert and download the data gathered and entered into the new DD/MH Integration system when that system is implemented.

5. Children's Mental Health System of Care

In December of 1998, a contract was developed between the Department of Health and Welfare and the Human Service Collaborative to conduct a needs assessment of Idaho's children with serious emotional disturbance and their families. On June 29, 1999 the completed assessment was presented to the Department of Health and Welfare, the Idaho Federation of Families for Children's Mental Health, the State Department of Education, the Department of Juvenile Corrections, the Governor's office, and various service providers. Added to the Needs Assessment was a cover letter signed by each of the Directors of the above named agencies. This letter states the commitment of each of these agencies to build a collaborative entity that will fulfill the recommendations of the Needs Assessment on behalf of Idaho families and their children with an emotional, behavioral, or mental disorder.

A plan for implementing the 50 recommendations of the 1999 Needs Assessment was negotiated between the State and Plaintiff attorneys in the Jeff D. lawsuit. The plan was filed with the court on February 9, 2001. The Federal Court approved the plan on June 4, 2001. This plan has major implications for the mental health delivery system for children. It sets forth a framework for community collaboration and has implications for service delivery for the Department of Health and Welfare, Department of Juvenile Corrections and Department of Education. The plan has specific action items with associated implementation dates.

As part of the court approved plan, the Governor established through Executive Order, the Idaho Council on Children's Mental Health (ICCMH). Lieutenant Governor Jim Risch chairs this cabinet level council. Some of the responsibilities of the ICCMH are to oversee the implementation of the plan and inter agency coordination.

Regional and Local Councils are being developed in the seven regions within the state. Councils will be comprised of child serving agencies, providers and parents. These councils will assist in the development and delivery of coordinated, community based services. The Regional Councils will report to the ICCMH on services, outcomes and service gaps.

The ICCMH is guiding the Department's implementation of the court-approved plan. The council provides a structured method for implementation and completion of the action items in the plan. The ultimate outcome of the plan will be the development of a coordinated community based system of care for publicly funded children's mental health services. The plan has specific action items with associated timelines for completion. The majority of the action items have been implemented as of the writing of this plan. These action items are consistent with the Block Grant Criterion and will form the basis of the objectives for the next year.

The Governor requested additional funding and personnel for children's mental health in two of the last three years. In 2001 the Legislature approved the governor's request and added another 15 staff and nearly $3.2 million in the Children and Family Services budget for children's mental health (CMH) services and in the 2002 session the legislature approved funds for 10 new children's mental health positions and additional children's mental health services. Medicaid also received an additional $2.5 million in combined state and federal funding for expected increases in Medicaid funded mental health services for children during the 2001 session. However, because of Idaho's fiscal difficulties, children's mental health shared in the need to reduce spending and reduce CMH staff by 14.5 FTE.

6. Interagency Work Group on Mental Health & Substance Abuse

A work group consisting of representatives of the Idaho Department of Health and Welfare, the Idaho Association of Counties and the Idaho Hospital Association are examining our current public system of care for both mental health and substance abuse. This group is interested in proposing changes to financing and service delivery in Idaho relating to both mental health and substance abuse services. The State Planning Council on Mental Health is represented on this work group by Arnold Kadrmas, M.D. It is anticipated that specific recommendations will be forthcoming from this work group during FY04.

7. Drug Courts

The Idaho Drug Court Act became effective July 1, 2001 and expanded drug courts to each of Idaho's seven judicial districts. Implementation of Drug Courts requires intensive teamwork at both the state and county level, including close collaboration of state agencies, particularly the Department of Health and Welfare, Departments of Correction and Juvenile Corrections, and the Idaho State Police.

Drug court teams work together to manage the drug court and plan each participants treatment, as well as, guide the sanctions and incentives for compliance with rigorous drug court requirements. Teams consist of prosecutors, defense attorneys, drug court coordinators, probation officers and treatment providers. Drug court treatment is provided by state certified providers, with most of the providers being a part of the statewide treatment network administered by the Department of Health and Welfare.

FFY2003 CHILDREN'S MENTAL HEALTH IMPLEMENTATION REPORT

A. BLOCK GRANT FUND EXPENDITURES SUMMARY

Block grant funds apportioned to Children's Mental Health were used to fund the services specified in the Idaho Mental Health Plan for Children: Fiscal Year *2003 (FY2003),* as shown below. Funds were awarded to one entity only: Department of Health and Welfare, P.O. Box 83720, Boise, Idaho, 83720-0036. The Director of the Department is Karl B. Kurtz. The total amount of the award for children and adult services for the period 10/01/02 - 9/30/2004 was $1,801,576.

The Children's Mental Health program allocated Federal Community Mental Health Block Grant (CMHBG) funds in FY2003 as follows:

$111,667 was allocated to the CMH Cost Pool for the delivery of an array of community-based mental health services.
$155,000 was used to fund a contract with the Idaho Federation of Families for Children's Mental Health for family support and advocacy services.
$55,000 is allocated for respite care, both direct services and contributed to a project to develop a statewide system of respite for families caring for special needs family member. The CMHBG funds are only used for services to children with SED and their families.

MENTAL HEALTH BLOCK GRANT
Phase 03, 10/1/02 – 9/30/04

	Federal Budget	**SFY 03 Expenditures**	**Total Remaining as of 9/30/03**
Adult Services	$ 923,947	$923,947	$ 0
Consumer/Family Empowerment	$ 132,000	$10,833	$121,167
State Planning Council	$ 20,000	$5,375	$14,625
Other Cons/Family Empowerment	$ 10,000	0	$10,000
Regional Budgets to Support Personnel	$ 291,315	$2,437	$288,878
Training	$ 12,568	0	$12,568
Total Adult Services	$ 1,389,830	$942,592	$447,238
Children's Services/ Jeff D	$ 111,667	0	$ 111,667
Respite Care	$ 55,000	0	$ 55,000
Family Support/Advocacy Contract	$ 155,000	0	$ 155,000
Total Children Services	$ 321,667	0	$ 321,667
Administration	$ 90,079	$90,079	0
TOTALS	$ 1,801,576	$1,032,671	$ 768,905

B. FY03 CHILDREN'S MENTAL HEALTH ACCOMPLISHMENTS

CRITERION 1

COMPREHENSIVE COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEMS: Establishment and implementation of a community-based system of care for adults with serious mental illness (SMI) and children with a serious emotional disturbance (SED), describing all available services including health (medical and dental), mental health, rehabilitation, case management, employment, housing, educational, other support services, and activities to reduce the rate of hospitalization of individuals with SMI or SED (previously criteria 1,3,4,6, and 7).

GOAL #1: **ENSURE THAT ALL CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES HAVE ACCESS TO AN ARRAY OF SERVICES WHICH EMPHASIZE COMMUNITY-BASED APPROACHES THAT ARE IN THE LEAST RESTRICTIVE SETTING AND HONOR THE CORE VALUES OF FAMILY INVOLVEMENT WITH NORMALIZED AND INDIVIDUALIZED CARE.**

Objective 1.1: **All families will have the opportunity to provide input on the services their child receives from the Department through the use of a family satisfaction survey.**

Narrative 1.1: ACTIVITIES: All families of children receiving services from the Department's CMH program are encouraged to complete a family satisfaction survey. The survey that is used was developed internally and collects data in the following areas:

1. Family Inclusion
2. Access
3. Appropriateness
4. Effectiveness

Families are provided the opportunity to complete the survey every 120-days and upon completion of services. The surveys are handed to families at the 120-day review or mailed out. All the surveys are administered by the Department of Health and Welfare.

There were 1,038 surveys returned and based on the total served population of 4,317, realizing a return rate of 24% (may represent some duplication).

CHANGES IN IMPLEMENTATION STRATEGIES: There have been no changes to the implementation strategies as described in the objective and in the Block Grant Application.

INNOVATIVE/EXEMPLARY MODELS: The Department has developed its own family satisfaction survey, which has been in use consistently for three years. The Department is currently moving towards using the MHSIP family satisfaction survey.

OUTCOME: This objective has been ACHIEVED.

Population:	**Children with SED and their parents**
Criterion:	**Comprehensive community based mental health services.**
Brief Name:	Family satisfaction
Indicators:	? Percent of reporting families whom rate access to service positively. ? Percent of reporting families whom rate appropriateness of services positively. ? Percent of reporting families who rate involvement in service decision making positively. ? Percent of reporting families whom rate effectiveness of services positively.
Measure:	
Numerator	Number of families reporting positively for each indicator.
Denominator	Total number of families reporting.
Sources of Information:	Family satisfaction surveys received and database used to record responses.
Special Issues:	Families will be given the opportunity to fill out a family satisfaction survey every 120 days and upon completion of services. Only those surveys returned will be recorded in the database. The input will provide the baseline of service satisfaction for which quality improvement will be measured in the coming years.
Significance:	Parental input is essential to the development, design and improvement of a comprehensive system of care.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator:	93.1%	93.9%		
1. Percent of reporting families who rate access to service positively.	97.3%	97.6%		
2. Percent of reporting families whom rate appropriateness of services positively.	93.8%	95.7%		
3. Percent of reporting families who rate involvement in service decision making positively.	97.2%	97.5%		

4. Percent of reporting families whom rate effectiveness of services positively.				
Value:				
Numerator: Number of families reporting positively for each indicator.				
1. Access	___595___	___974___	___N/A___	___100%____
2. Appropriateness	___622___	___1013__	___N/A___	
3. Family Involvement	___600___	___993___	___N/A___	
4. Effectiveness	___621___	___1012__	___N/A___	
5.				
Denominator: Total number of families reporting.	___639___	___1038__	_____	_____

Objective 1.2: **Fourteen (14) local councils will be operational under the primary direction of the ICCMH with the Department taking the lead in the development of the local councils.**

Narrative 1.2: ACTIVITIES: The ICCMH, with the Department having taken the lead, has chartered seven (7) Regional Children's Mental Health Councils and 31 Local Children's Mental Health Councils. There councils are collaborations on the local level to extend the system of care to communities. The Local Councils work directly with children and their families in their own communities to develop coordinated plans for service to children with SED that are involved in multiple systems. Local Councils include participants from local school districts, the Department of Juvenile Corrections, county probation, the Department of Health and Welfare, private providers and families of children with serious emotional disturbance.

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: The Department and the ICCMH believes this to be an exemplary model of service delivery. Collaboration at the local and state levels is necessary to the development and implementation of a system of care. Creating a system that allows families with high needs children to receive coordinated services through one door is an innovative and exemplary model. These councils also are intended to examine the delivery system at the community level to identify gaps and community needs.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED
Criterion:	Comprehensive community based mental health services
Brief Name:	Local Councils
Indicators:	Number of local councils established
Measure:	Number of local council agreements that meet the standards established by ICCMH and the geographic area covered.
Numerator	
Denominator	
Sources of Information:	Local council agreements
Special Issues:	Local councils require participation of the local child serving agencies. There may be some difficulty in establishing local councils as many of the key agencies are separate governmental units and do not fall under the control of the ICCMH or the Department.
Significance:	The establishment of local councils will facilitate the development, enhancement, monitoring, and coordination of community based services. Local councils are necessary for interagency coordination, cooperation and collaboration at the community level.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Number of local councils established	7	31	14	100%
Value: Number of local council agreements that meet the standards established by ICCMH and the geographic area covered.	7	31	14	100%
Numerator: _____ **Denominator:** _____	_____ _____	_____ _____	_____ _____	_____ _____

Objective 1.3: **The Department will implement a system of evaluating outcomes for youth served by Children and Family Services (CFS). The outcomes will be measured using the Children and Adolescent Functional Assessment Scale (CAFAS).**

Narrative 1.3: ACTIVITIES: The Department has implemented the CAFAS for use in tracking outcomes of children with SED. All children receiving services

through the Department's CMH program are rated on the CAFAS initially, every 120-days, and upon termination of services. The CAFAS results are entered into a database that is able to process the data and report on both case and system outcomes. The data collected through use of the CAFAS is used to help clinicians and families make decisions regarding effectiveness of services and case specific outcomes, but also to evaluate the service delivery system as a whole to determine system needs and change strategies.

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: The CAFAS is a recognized tool for rating functional impairment in children. The Department has adopted the CAFAS for use both internally and with providers in order to track the effectiveness of mental health services provided to children with SED and their families. The Department is moving to an outcomes-based model that can help to make treatment decisions and the CAFAS is one of the tools used to achieve this goal.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED
Criterion:	Comprehensive community based mental health services
Brief Name:	CAFAS outcome data
Indicators:	Percent of children for with a positive change in the CAFAS score over time. The CAFAS score will serve as the basis for determining functional impairment for this indicator. A CAFAS will be recorded upon initiation of services, at 120 day intervals and upon completion of services.
Measure:	
Numerator	Number of children receiving services with an improved CAFAS score.
Denominator	Total number of children receiving an initial CAFAS and an additional CAFAS following services.
Sources of Information:	Database used to record CAFAS scores.
Special Issues:	CAFAS is a method to measure a child's overall functional impairment. While the overall score may improve, a child may still experience difficulties in specific functional areas. Families and children may drop out of services prior to 120 days making a second CAFAS score difficult to accomplish.
Significance:	Improved functioning demonstrates the effectiveness of service interventions and leads to successful community integration of children with SED.

	FY 2002 Actual	FY 2003 Actual	FY 2003 Objective	% Attainment
Performance Indicator: 1. Percent of children for with a positive change in the CAFAS score over time. The CAFAS score will serve as the basis for determining functional impairment. A CAFAS will be recorded upon initiation of services, at 120-day intervals and upon completion of services.	24%	19%		100%
Value:				
Numerator: Number of children receiving services with an improved CAFAS score.	___406___	___362___	__N/A___	___100%____
Denominator: Total number of children receiving an initial CAFAS and an additional CAFAS following services.	___1725__	___1955__	__N/A___	_____

Objective 1.4: **An array of community-based services for children with SED will be available through CFS. These services will include assessment, case management, therapeutic foster care, respite care, crisis response, outpatient services, residential/group care, day treatment, and family support.**

Narrative 1.4: ACTIVITIES: Over the past two years, the Department and partners have been working towards the development of an array of community-based services for children with SED and their families. Appendix G in the Block Grant Application contains a list of the core services and their definitions, of which nine are considered in the continuum of community-based services. While the array of services area available to some extent across the state, the Department has developed and implemented core services practice standards that makes each of the seven (7) regions of the state responsible for ensuring that all of the core services are available to children and families. The Department continues to evaluate the service needs of the seven (7) regions and will work towards expanding capacity to meet the needs.

The Department's information system (FOCUS) in now capable of extracting information regarding utilization of the ten core services, which allows the Department the opportunity to establish a baseline of service

utilization. Some data reported last year has been updated as reporting processes are improved.

CHANGES IN IMPLEMENTATION STRATEGIES: A change in the Psychosocial Rehabilitation (PSR) program made it possible for private mental health providers of PSR services to complete their own comprehensive assessments, service planning, and functions of case management which used to be the sole responsibility of the CMH program. This has realized an increase in the PSR services, but reflects a reduction in the number of assessments and case management services conducted by the mental health authority.

Additionally, many of the past recipients of PSR were captured in the outpatient service category. The reduction is outpatient services demonstrates not a reduction in overall services, but a reduction in the number of children listed in the CFS database as receiving services. The number of outpatient services list in the table below, is a more accurate count of those children receiving outpatient services not funded by Medicaid.

INNOVATIVE/EXEMPLARY MODELS: These services are considered the standard of what the Department is to establish. There are examples in specific communities of innovative and exemplary models, but until the core services are developed statewide, the Department will focus its efforts on the core service array.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED and their families
Criterion:	Comprehensive community based services
Brief Name:	Community based service array
Indicators:	Numbers of children with SED who receive a specific community based service. The Department will establish a method for tracking and reporting utilization of an array of community based services
Measure:	Number of children receiving the specific service within the year.
Numerator	
Denominator	
Sources of Information:	Medicaid and FOCUS, CFS information system
Special Issues:	The CFS information system is now at a point where numbers of services can now be tracked. This will be the first year of this kind of comprehensive automated system reporting. Tracking services over time will indicate service enhancement.
Significance:	An array of community based services is essential for a comprehensive System of care to serve children with SED and their families.

	FY 2002 Actual	FY 2003 Actual	FY 2003 Objective	% Attainment
Performance Indicator: Number of children with SED who receive a specific community based service. The Department will establish a method for tracking and reporting utilization of an array of community based services.	See Below	See Below		
Value: Number of children receiving the specific service within the year. Assessment:	1802	1143		
Outpatient Services:	886	501		
Respite Care:	53	88		
Therapeutic Foster Care:	42	93		
Case Management Services:	2282	1935		
Family Support Services:	149	150		
Crisis Response Services:	295	253		
Residential Treatment Services:	120	128		
Day Treatment	43	142		
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

Objective 1.5: **A statewide system of respite care will be developed to serve children with SED and their families.**

Narrative 1.5: ACTIVITIES: The Department has been working towards the development of a system of respite care that will meet the needs of families that have children with SED, but also to meet the needs of

families across the spectrum of special needs and across the lifespan. The project has continued to work towards this end over the last year. The statewide respite system will include:

- The formation of a statewide coalition
- Awarding a contract for the development of the necessary infrastructure
- The development of a training manual and the delivery of training to respite providers
- Disability specific resources for respite providers
- Training for families regarding how to access the service and how to select an appropriate provider
- A statewide database of respite providers that can be accessed by the community through the state's information and referral system
- A single door for access to services that will fund services based on the specific special needs of the family member

To date, the project has achieved many of these milestones, including the formation of the Idaho Respite Coalition, a draft training manual, a contract has been awarded to develop the necessary infrastructure, and has begun to pull in the resources for providers on caring for children with specific needs.

Respite is one of the Department core children's mental health services. The CMH program has respite care available statewide, but continues to lack coordination with other systems of respite care that are delivered through different programs. The Departments FOCUS database contains all of the providers that are identified as resources for respite care, but this system is not accessible to individuals outside of the CFS program. There are a total of 1,079 providers of respite listed as resources in the FOCUS system, ranging from individuals to foster families and organizations.

CHANGES IN IMPLEMENTATION STRATEGIES: The only change to the implementation strategy is the timeline. The Idaho Respite Coalition continues to address the barriers to a statewide system and is continuing to work towards the eventually goal of a single coordinated, statewide system across disabilities and across the lifespan.

INNOVATIVE/EXEMPLARY MODELS: The Idaho Respite Coalition believes this is an innovative and exemplary model for service delivery as it offers families the ability to access respite care through a single seamless process, regardless of disability and regardless of age. It is also an example of a private/public partnership as the system is being developed to give private organizations a structure for the delivery of respite care.

OUTCOME: This objective has been PARTIALLY ACHIEVED.

Population:	Children with SED and their families
Criterion:	Comprehensive community based mental health services
Brief Name:	Respite Care
Indicators:	Number of registered providers that are listed on the statewide database for respite care
Measure:	Total number of registered respite care providers
Numerator	
Denominator	
Sources of Information:	Idaho CareLine Database
Special Issues:	Individuals other than registered providers can provide respite care if the family chooses, however in order to be on the database a provider will need to be registered.
Significance:	The number of registered respite care providers is indicative of the number of training that occurs and will set a baseline from which to expand, as there is currently no database nor are there any registered providers.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Number of respite care providers	Unknown	1079	N/A	100%
Value: Number of respite care providers that are registered and listed on the statewide database.	Unknown	1079		
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

Objective 1.6: **The Department will lead the effort in the development of a crisis response system that covers each of the seven (7) regions of the state.**

Narrative 1.6: ACTIVITIES: Under the direction of the ICCMH, the Department took the lead in pulling together a group of stakeholders to prepare a set of standards for the development of community crisis response protocols. The stakeholders included leaders from schools, juvenile justice, public and private mental health providers, law enforcement, parents and families of children with SED, psychiatric hospitals, emergency rooms, and higher education. Following the development of the protocol standards and the approval of the ICCMH, it was forwarded on to the seven (7) Department

regions and the Regional and Local Councils for development of regional or local protocols for crisis response.

While meeting the standards, the development and implementation of the protocols is expectedly different across the state. In some areas of the state a single protocol was developed to cover the entire region and others created several protocols that cover individual communities within the region.

The final outcome of the process is that crisis response protocols were developed across the state and, while looking differently from area to area. In total, there are 18 protocols for crisis response and these protocols cover the entire state.

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: In a state that is primarily rural and in some cases frontier in designation, having a crisis response system that is governed by community protocols is an exemplary model. The protocols even identify that children in need of transportation for mental health emergencies should be transported by the least restrictive means possible to avoid the traumatic experience of having to be handcuffed and transported by law enforcement in an already traumatic situation.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED and their families
Criterion:	Comprehensive community based mental health services
Brief Name:	Crisis Response
Indicators:	Number of crisis response protocols
Measure:	Number of signed crisis response protocols that cover the state by region, county or community.
Numerator	
Denominator	
Sources of Information:	Regional Department office reports
Special Issues:	The Jeff D court plan requires the Health and Welfare, Corrections and Education to participate in the development of the protocols, but many other local entities that are involved in the system are not bound to cooperate. This many create difficulty in getting some agencies to participate and contribute to the crisis response system. Additionally, some protocols will be region wide and some regions may choose to develop protocols on a more local level.

Significance:	The protocols with coordinate the emergency mental health system throughout the state as required by the Jeff D court plan and the Children's Mental Health Services Act.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Number of crisis response protocols	0	18	7	100%
Value: Number of crisis response protocols that have been signed and cover a specific geographic area.	0	18		
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

CRITERION 2

ESTIMATES OF PREVALENCE AND TREATED PREVALENCE OF MENTAL ILLNESS: The plan contains estimates of the incidence and prevalence in the state of SMI and SED and contains quantitative targets to be achieved in the implementation of the mental health system, including the numbers of individuals with SMI and SED to be served (previously criteria 2 and 11).

GOAL #2: **ENSURE THE DEPARTMENT OF HEALTH AND WELFARE, THROUGH ITS REGIONAL CFS PROGRAMS AND MEDICAID, PROVIDES MENTAL HEALTH SERVICES TO CHILDREN REPRESENTING THE TARGET POPULATION.**

Objective 2.1: **Increase by 5% the number of children served through Medicaid and CFS programs**

Narrative 2.1: ACTIVITIES: The performance indicator table for this objective outlines the combined increase in numbers of children provided a mental health service through Medicaid and the CFS CMH program. The CFS program increased from 3,870 served in fiscal year 2002 to 4,317 served in fiscal year 2003. This represents an increase of 11.4%. The Idaho Medicaid's CMH services increased from 10,141 served in fiscal year 2002 to 11,444 served in fiscal year 2003. This represents an increase of 12.6 percent. Of those children served by Medicaid, only 2,228 are known to have a SED.

CHANGES IN IMPLEMENTATION STRATEGIES: In last years report it was noted that the Medicaid reports did not include EPSDT service

coordination or school mental health services, however the difficulty causing this problem has been fixed and the fiscal year 2002 data and the fiscal year 2003 data is accurate.

INNOVATIVE/EXEMPLARY MODELS: The methods of reporting these numbers are reflective of the continuous effort on behalf of the Department to ensure that the information systems are reporting accurate data. In Idaho, the Department's efforts for reporting CMH data is a priority as reflected by the progress made in the past year to the information systems reporting capacities.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED.
Criterion:	Prevalence and number served
Brief Name:	Target Population Served
Indicators:	Percentage of children that receive publicly funded mental health services.
Measure:	
Numerator	Number of children receiving services utilizing public monies for the year.
Denominator	The number of youth estimated to have a serious emotional disorder using prevalence figures this past year.
Sources of Information:	Medicaid reports and FOCUS, the CFS information system.
Special Issues:	The Medicaid figure showing the total number of children/youth served is important in that it shows the number of youth receiving publicly funded services through the private service system providers. These youth are in addition to those who are served by the DHW regional service offices. The total of both groups closely approximates all children/youth served through public funds available through the Department of Health and Welfare and is, therefore, considered part of the public service system. One caveat is that the information system cannot ascertain which of those youth served through Medicaid funding in the private provider clinic setting have conditions serious enough to be considered a serious emotional disorder. Certainly some do have a serious emotional disorder while others may not meet the severity criteria. We are also unable to determine the number of youth with a serious emotional disorder receiving services in the private sector not utilizing private resources.
Significance:	Service capacity should increase over time with the development of more community based services. Increased capacity allows for more children to be served. Measurement of capacity and services is essential to the development of an adequate system of care to meet the needs of youth with SED and their families.

	FY 2002 Actual	FY 2003 Actual	FY 2003 Objective	% Attainment
Performance Indicator: 1. Percentage of children receive publicly funded mental health services.	75%	85%	80%	100%
Value:				
Numerator: Number of children receiving services utilizing public monies for the year.	__14,011_	__15,761_	__14,711_	_____
Denominator: The number of youth estimated to have a serious emotional disorder using prevalence figures in application.	__18,452_	__18,452_	_____	_____

Objective 2.2: **Maintain local agreements or contracts to facilitate special population's access to services.**

Narrative 2.2: ACTIVITIES: As reported in the Block Grant Application, the Department has in the past only reported one specific contract/agreement to facilitate special population's access to services. In the below performance indicator table you will see that the Department has maintained three contracts/agreements for facilitating special populations access to services. Those contracts/agreements are described below. It is important to affirm that although only three contracts/agreements are reported in the performance indicator table, Idaho is considered primarily a rural/frontier state and has many contracts and agreements to serve these rural geographic populations.

Region III has a high Hispanic population and has in the past had difficulty helping that those families access services. To assist in the facilitation of access to children's mental health services for Hispanic children, Region III Children and Family Services has contracted with the Hispanic Commission to assist the Department in facilitating equal access for Hispanic children and families.

Region IV has a contract with an interpreter service to assist in communicating with children and families that do not speak English well enough to have equal ease in accessing mental health services. There is an increasing Bosnian population as well as Spanish speaking population that benefit from the assistance of an interpreter to communicate with those involved in the Children and Family Services programs.

Region V has a contract with a clinician to do psychotherapy with children that have a hearing impairment. This contract assists in delivering

services to children and families that cannot benefit from services that are primarily delivered verbally.

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: Recognizing the rural geography of Idaho, the Children's Mental Health system, out of necessity, has developed innovative models for service delivery in remote areas of the state. Examples of these programs include videoconferencing for psychiatric services and the recruitment/enhancement of private providers to serve these often difficult to reach populations.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED.
Criterion:	Prevalence and number served
Brief Name:	Special Populations Served
Indicators:	Number of agreements or contracts.
Measure:	Number of agreements or contracts.
Numerator	
Denominator	
Sources of Information:	Regional Program Managers or contract officers
Special Issues:	Culturally relevant access to and delivery of services is necessary to increase services to special populations. Having contractors or state staff able to provide this is challenging given Idaho's demographic makeup. Future reporting requirements will be able to measure the impact on numbers served. The measurement will then be modified to document the number served as compared to previous years to show the impact of this objective.
Significance:	Making the access and services culturally relevant can increase the number of special population children served.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Number of agreements or contracts.	3	3	3	100%

Value: Number of agreements or contracts.	3	3	3	100%
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

CRITERION 3

INTEGRATED CHILDREN'S SERVICES PROVISION: The plan provides a comprehensive system of integrated community mental health services appropriate for the multiple needs of children (previously criterion 9).

GOAL #3: **ENSURE A SYSTEM OF INTEGRATED SOCIAL SERVICES, EDUCATIONAL SERVICES, JUVENILE CORRECTIONS SERVICES, AND SUBSTANCE ABUSE SERVICES TOGETHER WITH MENTAL HEALTH SERVICES, SUCH THAT CHILDREN WITH SED AND THEIR FAMILIES CAN RECEIVE CARE APPROPRIATE FOR THEIR MULTIPLE NEEDS.**

Objective 3.1: **Local councils will be established and will staff and coordinate care for youth and families served by the councils.**

Narrative 3.1: ACTIVITIES: The ICCMH, with the Department having taken the lead, has chartered seven (7) Regional Children's Mental Health Councils and 31 local councils. These councils are collaborations on the local level to extend the system of care to communities. The Local Children's Mental Health Councils work directly with children and families in their communities to develop coordinated plans for serving the most difficult problems. Local councils include participants from local school districts, the Department of Juvenile Corrections, county probation, the Department of Health and Welfare, private providers and families of children with serious emotional disturbance.

Many of these local councils are still in the developmental stage and just beginning to staff children and families in need. The numbers reported in the performance indicator table reflect the current stage of development that the councils are in. The first step in the development of the councils was to establish pilot or demonstration sites. Three demonstration sites were operational for two years, ending June 2002.

Of course there are many other children that are involved in more than one child serving system, but the purpose of this objective was to define the population of children that are being served by more than one agency through collaboration. The 2% as stated in the performance indicator table represents only those children that have received a staffing at a local council meeting.

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: The Department and the ICCMH believe this to be an exemplary model of service delivery. Collaboration at the local and state level is necessary to the development and implementation of a system of care. Creating a system that allows families that have high need children to receive coordinated services through one door is an innovative and exemplary model of service delivery. These councils also are intended to examine the delivery system at the community level to identify gaps and community needs.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED
Criterion:	Comprehensive community based services for children
Brief Name:	Local Council services
Indicators:	Percentage of children with SED who are also involved in other child serving agencies.
Measure:	
Numerator	Number of children for whom a local council held a staffing.
Denominator	Total number of children served by CFS
Sources of Information:	Local Councils and FOCUS, CFS information system
Special Issues:	The court-approved plan calls for the establishment of seven local councils by March 1, 2002. Establishment will mean that local councils have agreements in place and have the ability to staff cases. Local councils will provide the method for coordinating and collaborating across agencies for the child's care. Children referred to the local council will be involved in more than one child-serving agency. The number of youth served will be measured over time. This is the first year of local councils in each area of the state. Increases in number of youth served by local councils can be monitored over time.
Significance:	Interagency collaboration at the local level will ensure a comprehensive community based system of care for children.

	FY 2002 Actual	FY 2003 Actual	FY 2003 Objective	% Attainment
Performance Indicator: 1. Percentage of children with SED who are also involved in other child serving agencies.	2%	2.5%		100%
Value:				
Numerator: Number of children for whom a local council held a staffing.	___94____	___110___	___N/A___	_____
Denominator: Total number of children served by CFS.	___3870__	__4317___	___N/A___	_____

CRITERION 4

TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS: The plan provides for the establishment and implementation of a program of outreach to and services for individuals with SMI or SED who are homeless; and additionally describes the manner in which mental health services will be provided to individuals residing in rural areas (previously criteria 8 and 10).

GOAL #4: **ENSURE THAT FAMILIES RESIDING IN RURAL ARES HAVE ACCESS TO SERVICES FOR THEIR CHILDREN WITH A SED.**

Objective 4.1: **Twenty five percent (25%) of children served by the Department's Mental Health programs are from rural areas.**

Narrative 4.1: ACTIVITIES: Idaho is considered to be a rural or even frontier, state because of the large geographical area and the low population in many of those areas. The Department considers the children and families living in rural areas to be a special population, requiring additional planning and resources to ensure access to mental health services. This objective is to ensure that rural Idaho receives an equal or representative share of mental health services. It is clear that families living in the rural areas do not often have the same access to an array of mental health services as do those in more urban areas, however, reaching as many children and families in rural communities is a significant measure of the effectiveness in outreach and rural service development.

The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located. This is determined by factoring out from the total of children served within the system, the

number of children served in Idaho's seven most populated counties: Kootenai, Nez Perce, Canyon, Ada, Twin Falls, Bannock, and Bonneville. These counties may also be considered rural based on the population and size of geographical area.
As seen in the performance indicator table below, 26.2% of those served by the Department's Children's Mental Health program live in rural areas of the state.

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: Recognizing the rural geography of Idaho, the Children's Mental Health system, out of necessity, has developed innovative models for service delivery in remote areas of the state. Examples of these programs include videoconferencing for psychiatric services and the recruitment/enhancement of private providers to serve these often difficult to reach populations.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED
Criterion:	Services to rural and homeless populations
Brief Name:	Services to rural and homeless populations
Indicators:	The percentage of children receiving publicly funded services that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located. This is determined by factoring out from the total of children served within the system, the number of children served in Idaho's seven most populated counties: Kootenai, Nez Perce, Canyon, Ada, Twin Falls, Bannock, and Bonneville.
Measure:	
Numerator	The number of children/youth served from rural areas.
Denominator	The total number of children/youth served across all counties/field offices.
Sources of Information:	Divisional information systems and Medicaid database.
Special Issues:	The figures reflecting numbers of children served represent both those youth receiving community-based services through DHW's regional programs and youth receiving Medicaid-funded services through the private provider service sector. Children receiving PSR services are SED. The percentage youth included in the above figures who are served by Medicaid clinic option in the private sector and who meet serious emotional disorder eligibility criteria are not known. The most that the Medicaid data system can provide is a diagnosis, and diagnosis

	alone is not sufficient to determine serious emotional disorder.
Significance:	Idaho is a very rural state. A large percentage of Idaho citizens reside in rural areas. It is important for citizens that they have access to services in rural areas. Rural service delivery is a requirement of federal law if states are to receive federal block grant monies.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. The percentage of children receiving publicly funded services that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located. This is determined by factoring out from the total of children served within the system, the number of children served in Idaho's seven most populated counties: Kootenai, Nez Perce, Canyon, Ada, Twin Falls, Bannock, and Bonneville.	41%	26.2%	25%	100%
Value:				
Numerator: The number of children/youth served from rural areas.	__1594___	__1131___	__1079___	_____
Denominator: The total number of children/youth served across all counties/field offices.	__3870___	__4317___	_____	_____

CRITERION 5

MANAGEMENT SYSTEMS: The plan contains a description of the financial resources, staffing and training necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training of providers of emergency health services regarding mental health. Also, the plan describes the manner in which the state intends to expand the grant for the fiscal year involved to carry out the provisions of the plan (previously criteria 5 and 12).

GOAL #5: PRIORITIZE FUNDING FOR COMMUNITY-BASED SERVICES TO ENSURE APPROPRIATE RESOURCE ALLOCATION OF THE COMMUNITY-BASED SYSTEM, AND TO ENSURE CONTINUOUS QUALITY IMPROVEMENT OF THE SERVICE SYSTEM.

Objective 5.1: Seventy five percent (75%) of all funding for children's mental health services will be spent on community-based services.

Narrative 5.1: ACTIVITIES: As stated in the Black Grant Application, the state of Idaho has been involved in a federal class-action lawsuit for 22 years. The major push of the lawsuit is to develop a continuum of community-based services for children and their families. The Department and partners have made this a priority and, although slow, have made significant progress in the development of the core services outlined in Appendix G of the Block Grant Application. With the development of the community-based services, as expected, the need for inpatient services has decreased. The performance indicator table below presents the number of dollars that have been spent on community-based services.

In the Children's Mental Health Program, the Department (including both Medicaid and the Mental Health Authority) has spent approximately $40,814,003 on children's mental health services. Of this amount $33,723,934, or approximately 82.6%, has been spent on community-based services (non-inpatient).

CHANGES IN IMPLEMENTATION STRATEGIES: There are no changes to the implementation strategies as described in the objective and in the Block Grant application.

INNOVATIVE/EXEMPLARY MODELS: Again, these practices are not innovative or exemplary above national trends, but are exemplary in the Idaho system. Idaho has not always made the development of community-based services a priority, but has in recent years and begun to create a

children's mental health system that utilizes research-based best practices to develop new approaches.

OUTCOME: This objective has been ACHIEVED.

Population:	Children with SED
Criterion:	Management Systems
Brief Name:	Expenditures on community-based programs
Indicators:	Percentage of total children's mental health funding, including block grant funds, expended for community based services.
Measure:	
Numerator	Amount of children's mental health funding for community based programs (non-hospital care and expenditures).
Denominator	Total funds spent on all children's mental services including State Hospital South and other hospitalizations funded by Medicaid or contracts.
Sources of Information:	Divisional information systems, Division of Management Services information systems, and Medicaid system information.
Special Issues:	Many/most hospitalizations are most appropriately considered community-based, especially if the hospital is located in the child's home community and if the admission is for short-term crisis stabilization. However, in Idaho, many of the inpatient units receiving public funds (Medicaid) are long distances from the child's home and some of the stays are longer than short-term crisis stabilization. The data system cannot differentiate which admissions may be local and short term versus distant and longer term. Subsequently, for purposes of this performance indicator community-based services are defined as outpatient services that clearly are community-based and are less restrictive.
Significance:	A community-based service system is a core value for the state as well as being a standard for the field. Community-based services have been shown to be the most normalized, the most effective and the most cost efficient services. Data systems are needed which address not only client encounter and funding data parameters, but also quality and service effectiveness measures.

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Percentage of total children's mental health funding, including block grant funds, expended for community based services.	82%	82.6%	75%	100%
Value:				
Numerator: Amount of				

children's mental health funding for community based programs (non-hospital care and expenditures).	$32,851,186	$33,723,934	$30,610,502	_____
Denominator: Total funds spent on all children's mental services including State Hospital South and other hospitalizations funded by Medicaid or contracts.	$39,646,470	$40,814,003	_____	_____

Objective 5.2: **The Department will implement a continuous quality improvement (CQI) system to ensure utilization and outcome data is used to improve the Department's service delivery system.**

Narrative 5.2: ACTIVITIES: The Department has developed a CQI plan for the CMH program, which went into effect June of 2003. The CQI plan is broken down into three main components:

- External Review System
- Internal Review System
- Case Review.

The external review systems section of this plan addresses those quality improvement activities that are conducted by people outside of the Department. The internal review systems are those activities conducted by the Department personnel. The case review is a specific formal review of individual CMH cases.

The Department has many ongoing external reviews that currently provide feedback to the CMH system and help to identify needed changes, including the Idaho State Planning Council on Mental Health and the federal court judge in the aforementioned Jeff D lawsuit. Internally, there are many CQI activities including supervisory reviews, outcome indicators and utilization data and family satisfaction surveys.

The Department is currently in the process of developing a single instrument for case review to be used statewide. The instrument will evaluate cases based on five outcome indicators:

- Family Inclusion
- Access to Services
- Appropriateness of Services
- Effectiveness of Services
- Cultural Competence

The data reported in the performance table for this objective does not necessarily reflect all the activities that have occurred for CQI, but instead establishes the number of times that the major external stakeholder bodies met for the purpose of reviewing the CMH program. The internal review portion of this objective estimates the number of times the major internal stakeholder groups met for purposes of reviewing the CMH program for identification of needs. Not reported here are the case reviews that happen on each case on a local level. Supervisory reviews occur on each case during the first 30-days, every 120-days, and upon completion of assessments and individualized service plans.

CHANGES IN IMPLEMENTATION STRATEGIES: The only change in the strategy for implementation is the still undeveloped case review tool. Many case reviews occur across the state, but are completed at the supervisor or manager level. Therefore, there is not a single system in place for this function until the case review instrument is developed and implemented.

INNOVATIVE/EXEMPLARY MODELS: The Department believes that a statewide system of CQI is an innovative model only if the gathered information is evaluated and used to determine the need for change. Additionally, the case review tool that is being developed is modeled in some ways after the process used for the Child and Family Services Review.

OUTCOME: This objective has been PARTIALLY ACHIEVED.

Population:	Children with SED and their families
Criterion:	Management Systems
Brief Name:	CQI
Indicators:	Number of specific reviews
Measure:	Number of specific reviews that take place on Department cases and programs.
Numerator	
Denominator	
Sources of Information:	Documented CQI reviews
Special Issues:	The Department is still in the process of developing the CQI system and the initial reviews will be a process of learning.
Significance:	The establishment of a CQI system will improve the quality of the Department's children's mental health system by utilizing data in meaningful ways.

	FY 2002 Actual	FY 2003 Actual	FY 2003 Objective	% Attainment
Performance Indicator: 1. Number specific reviews	Unknown	19	N/A	100%
Value: Number of specific reviews. External Reviews: Internal Reviews: Case Reviews:	 Unknown Unknown Unknown	 13 6 0	 N/A N/A N/A	 100%
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

FFY2003 ADULT MENTAL HEALTH IMPLEMENTATION REPORT

A. BLOCK GRANT FUND EXPENDITURES SUMMARY

Block grant funds apportioned to Adult Mental Health were used to fund the services specified in the Idaho Mental Health Plan for Adults: Fiscal Year *2003 (FY2003),* as shown below. Funds were awarded to one entity only: Department of Health and Welfare, P.O. Box 83720, Boise, Idaho, 83720-0036. The Director of the Department is Karl B. Kurtz. The total amount of the award for children and adult services for the period 10/01/02 - 9/30/2004 was $1,801,576.

The Adult Mental Health program allocated Federal Community Mental Health Block Grant (CMHBG) funds in FY2003 as follows:

- **$142,000** was allocated to fund contracts Mountain States Group for the Office of Consumer Affairs and Technical Assistance, the Idaho Chapter of the National Alliance for the Mentally Ill (NAMI-Idaho), and to support consumer and family member empowerment initiatives.
- **$291,315** was allocated to the seven regional CMHC programs to support their personnel budgets for clinical (direct service) positions.
- **$20,000** was allocated to support the meetings and activities of the Idaho State Planning Council on Mental Health and the Regional Mental Health Advisory Boards.
- **$12,586** was allocated to the Adult Mental Health Program to fund training activities.
- **$923,947** was placed in DHW's Mental Health Cost Pool and allocated to fund various regional community mental health center program categories by the use of a Random Moment Time Study.

MENTAL HEALTH BLOCK GRANT
Phase 03, 10/1/02 – 9/30/04

	Federal Budget	SFY 03 Expenditures	Total Remaining as of 9/30/03
Adult Services	$ 923,947	$923,947	$ 0
Consumer/Family Empowerment	$ 132,000	$10,833	$121,167
State Planning Council	$ 20,000	$5,375	$14,625
Other Cons/Family Empowerment	$ 10,000	0	$10,000
Regional Budgets to Support Personnel	$ 291,315	$2,437	$288,878
Training	$ 12,568	0	$12,568
Total Adult Services	$ 1,389,830	$942,592	$447,238
Children's Services/ Jeff D	$ 111,667	0	$ 111,667
Respite Care	$ 55,000	0	$ 55,000
Family Support/Advocacy Contract	$ 155,000	0	$ 155,000
Total Children Services	$ 321,667	0	$ 321,667
Administration	$ 90,079	$90,079	0
TOTALS	$ 1,801,576	$1,032,671	$ 768,905

B. FY03 ADULT MENTAL HEALTH ACCOMPLISHMENTS

It should be noted that any data in the Adult Plan Implementation Report represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts.

CRITERION 1

COMPREHENSIVE COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEMS: Establishment and implementation of a community-based system of care for adults with serious mental illness (SMI) and children with a serious emotional disorder (SED), describing all available services including health (medical and dental), mental health, rehabilitation, case management, employment, housing, educational, other support services, and activities to reduce the rate of hospitalization of individuals with SMI or SED (previously criteria 1, 3, 4, 6 and 7).

GOAL 1: TO IMPROVE ACCESS, QUALITY AND APPROPRIATENESS OF SERVICES TO THE TARGET POPULATION, AND DEMONSTRATE IMPROVED QUALITY OF LIFE AND POSITIVE OUTCOMES FOR THE TARGET POPULATION.

Objective 1.1: **To maintain at the level of the previous fiscal year the numbers of Hispanic/Latino consumers accessing services in Regions III and V.**

Narrative 1.1: ACTIVITIES: According to Year 2000 census data, 7.9% of Idaho's population was Hispanic with the predominant concentration residing in Regions III and V. Mental Health services in regions III and V are provided through the Department of Health and Welfare (DHW) operated Community Mental Health Centers (CMHC) and a network of private sector mental health providers.

Region III CMHC identified the following activities related to facilitating access to mental health services for Hispanic consumers:

1) Recruited in a bilingual clinician for the Assertive Community Team, and a bilingual social worker for the Community Treatment Team.
2) Provided on site consultation and training to Salud Y Provecho, a mental health agency with the Idaho Migrant Council.
3) Provided a clinical supervisor to serve as a liaison between the CMHC and Terry Reilly Health Services, a migrant health clinic, to staff cases, provide access to mental health care, partner, and enhance community roles.
4) Conducted mental holds and designated examinations of monolingual Spanish speaking clients by a bilingual and bicultural clinician.

5) PSR services are being delivered to the Hispanic population in their native tongue.
6) The nursing team is working with pharmaceutical companies to provide Hispanic consumers with educational material that is cultural sensitive and in Spanish for monolingual Hispanic clients. In addition written medication instructions are being given in Spanish to monolingual clients.
7) A bilingual and bicultural psychiatrist who primarily sees monolingual Spanish speaking clients is employed by the CMHC.

Region V CMHC identified the following activities related to facilitating access to mental health services for Hispanic consumers:

1) Hired a bilingual Physician's Assistant to provide medication management services.
2) Recruited two bilingual speaking staff in the adult mental health program.
3) Collaborated with the Development Disability program to provide translation services from bilingual DD staff when needed.

Forty nine Hispanic consumers were documented as receiving psychosocial rehabilitation services during FY03 in regions III and V.

CHANGES IN IMPLEMENTATION STRATEGIES: The following data represents only those Hispanic consumers receiving psychosocial rehabilitation services. Due to limitations with our current data tracking system, DHW is unable to track the total number of Hispanic consumers who received services during FY03. Additional services were provided to Hispanic consumers including emergency services, case management services and medication management services but were unable to be counted due to data tracking system limitations.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was ACHIEVED based on our current limited ability to collect this data element.

Objective 1.1 Indicator Data Table

Objective 1.1	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Latino access to services				
Value				
If Rate: **Numerator**: Number of Latino/Hispanic consumers receiving services in FY03	36	49	36	100%

Denominator: Number of Latino/Hispanic consumers receiving services in FY02.				

Objective 1.2: **To provide case management services to all persons who receive substantial amounts of publicly provided services.**

Narrative 1.2: ACTIVITIES: For the purposes of this plan, case management is defined as "the single point of responsibility for any given open case." Using this definition, in Idaho case management is provided to all individuals who meet the priority population definition and who are receiving substantial amounts of publicly provided services. In practice, the intensity of case management provided varies from individual to individual, as needed and appropriate. In this sense, there is a continuum of case management services which is available to each individual. This continuum varies in intensity from the most intense activities under Assertive Community Treatment and Community crisis response; services under Psychosocial Rehabilitation (PSR) and Targeted Case Management (CM); and, for example, less intense case management for those needing medication management only services. Counts include those consumers receiving ongoing PSR, CM and Clinic services.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was ACHIEVED. It should be noted that based on our current data system we are not able to guarantee unduplicated counts for this objective.

Objective 1.2 Indicator Data Table

Objective 1.2	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Case Management				
Value				
If Rate: **Numerator**: Number of ongoing consumers who receive case management services in FY03 **Denominator:** Number of ongoing consumers served in FY02.	6032	9291	6032	100%

Objective 1.3: **To maintain at the level of the previous fiscal year the consumer-reported satisfaction with psychosocial rehabilitation (PSR) services.**

Narrative 1.3: ACTIVITIES: Psychosocial rehabilitation services are provided under the authority of the Department and prior authorization by the seven regional mental health authorities. Services are provided by the regional Community Mental Health Centers and private sector providers in each of the seven regions. All consumers receiving psychosocial rehabilitation services are requested to voluntarily complete a customer satisfaction survey on an annual basis. The survey responses are then data entered into DHW's Visual Basic Rehabilitation Outcomes Database tracking system. Not all consumers who receive psychosocial rehabilitation (PSR) services are willing to complete/return the survey to the regional mental health authority unit for data entry. The Department remains committed to continuous quality improvement and identifies consumer satisfaction with services as an important measurement in assessing the quality and appropriateness of services.

CHANGES IN IMPLEMENTATION STRATEGIES: A change was required in how we measured this objective as the objective was originally written with a denominator of the number of consumers receiving PSR services. This is an incorrect calculation for this objective as satisfaction surveys are not required to be completed on all consumers receiving PSR, and the only viable measurement would be based on the number of completed satisfaction surveys.

INNOVATIVE/EXEMPLARY MODELS: Consumer satisfaction survey results are utilized as tools to measure quality and appropriateness of services and to assist the regional mental health authority units establish profiles of the private sector PSR providers. These profiles may then be used to assist consumers with making informed decisions related to provider selection.

OUTCOME: This objective was ACHIEVED based on the available data. Not all consumers who received PSR services returned or completed the survey.

Objective 1.3 Indicator Data Table

Objective 1.3	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Consumer reported satisfaction with PSR				
Value	90%	91%		
If Rate: **Numerator**: Number of adults				

with SPMI who rate positive satisfaction with services	1133	1225	1065	100%
Denominator: Number of completed satisfaction surveys entered into VBROD. (Number of adults with SPMI receiving publicly funded PSR services).	1261 (4360)	1351 (8873)	(3682)	

Objective 1.4 **To write and adopt a statewide cultural competency plan to more effectively and consistently identify the needs of and serve the growing cultural diversity in the state during FY2003.**

Narrative 1.4:

ACTIVITIES: The Division of Family and Community Services began the process of identifying and prioritizing core services and program goals for each of the Division programs. The Adult Mental Health Program identified a program goal to educate communities, providers, and regional & institutional programs on best practice methods for delivery of MH services which includes the strategy to provide training and technical consultation on Cultural Competence to identified stakeholders. Based on the identified core services, the Adult Mental Health Program has begun the process of developing program standards for each identified core service. The purpose of these standards is to provide direction and guidance to the Adult Mental Health (AMH) programs regarding services. The standards are intended to assist the program to achieve statewide consistency in the development and application of AMH core services. As part of the standards development, core values were identified and are to be incorporated in all program standards. The core values identify and emphasize that services be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial and ethnic differences of the populations they serve. The emphasis on cultural competence will continue to be prioritized in ongoing program standards development.

CHANGES IN IMPLEMENTATION STRATEGIES: As opposed to writing a separate plan, the priority and planning needs related to cultural competence have been incorporated into the ongoing planning and development of core program values, consistent programs standards and training needs.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was PARTIALLY ACHIEVED.

Objective 1.5: **To maintain the previous fiscal year's level of achieving and retaining competitive employment among those consumers receiving PSR service.**

Narrative 1.5:

ACTIVITIES: Each regional CMHC has an onsite vocational rehabilitation (VR) counselor under an agreement between DHW and the Idaho Department of Vocational Rehabilitation. The VR counselor is assigned to the regional Assertive Community Treatment (ACT) team and provides vocational services to the ACT consumers as well as other CMHC consumers. Available vocational services include work skills assessments, career counseling, rehabilitation plan development, and referrals to vocational and educational services such as job coaching, transportation, job shadowing, adult education and literacy services and transitional/sheltered work experiences. Idaho also distributes state community supportive employment (CSE) funds to each regional CMHC every July. As individual vocational rehabilitation plans are developed, funds are placed in individual accounts allowing consumers maximum choice of vocational service providers and flexibility in the budgeting/spending of these monies.

CHANGES IN IMPLEMENTATION STRATEGIES: A change in how we measured this objective was required as the objective was originally written with a denominator of the number of consumers receiving PSR services. This is an incorrect calculation for this objective as Baseline surveys were not completed and data entered on all consumers receiving PSR, and the only viable measurement would be based on the number of completed Baseline surveys.

INNOVATIVE/EXEMPLARY MODELS: The incorporation of a vocational counselor as an integral component of the ACT team is an exemplary model for practice.

OUTCOME: This objective was NOT ACHIEVED. It is believed that the continued downturn in the state's economy has had a significant impact in this area.

Objective 1.5 Indicator Data Table

Objective 1.5	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Competitive Employment				
Value	10%	8%		
If Rate: **Numerator**: Number of adults with SPMI receiving PSR services who report achieving	220	158	245	64%

independent competitive employment during FY03 **Denominator:** Number of completed Baseline surveys entered into VBROD (Number of SPMI adults receiving PSR services in Idaho.)	2173 (4360)	1952 (8873)		

Objective 1.6: **To maintain the previous year's level of achieving and retaining independent housing among those consumers receiving PSR services.**

Narrative 1.6: ACTIVITIES: DHW utilizes a number of strategies to support consumer goals related to living independently in their communities. Primary among these is the adoption of psychosocial rehabilitation services as the best practice standard. The basic philosophy of psycho social rehabilitation is that services are intended to promote the consumer's highest possible functional level through restoration and skill maintenance. Psychosocial rehabilitation services are intended to be community based and delivered in the consumer's home and community whenever possible.

A variety of community based supportive housing arrangements ranging from Residential and Assisted Living Facilities, Certified Family Homes and Semi-Independent Homes are available to consumers. Additionally, clients are assisted with accessing independent housing resources through Section 8 rental assistance programs, Southeast Idaho Community Action Agency (SICAA) rental subsidies and other various rental assistance programs.

DHW participates in the Shelter Plus Care program, which is a rental assistance program specific to persons who are mentally ill and homeless. Each of the seven regions currently has funding for rental assistance for 9 to 11 housing units. DHW has also actively supported the development of Oxford Houses throughout the State. Oxford Houses are group homes for persons who are in recovery from substance abuse. Each regional CMHC has also developed a variety of community housing resources unique to its area and housing resource availability.

CHANGES IN IMPLEMENTATION STRATEGIES: A change was required in how we measured this objective as the objective was originally written with a denominator of the number of consumers receiving PSR services. This is an incorrect calculation for this objective as Baseline surveys were not completed nor data entered on all consumers receiving

PSR. Therefore, the only viable measurement would be based on the number of completed Baseline surveys.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was ACHIEVED.

Objective 1.6 Indicator Data Table

Objective 1.6	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Assisted/supportive housing				
Value	72%	86%	72%	
If Rate: **Numerator**: Number of SPMI adults receiving PSR services who report achieving or maintaining at least an assisted/supportive living arrangement during FY03	1556	1677	1680	100%
Denominator: Number of completed Baseline surveys entered into VBROD	2173	1952		
(Number of adults with SPMI receiving PSR services in Idaho)	(4360)	(8873)		

Objective 1.7: **To maintain the previous fiscal year's level of persons seen for a first face to face appointment at their community mental health provider within 7 days of discharge from a state hospital.**

Narrative 1.7: ACTIVITIES: DHW places a high priority on reducing the rate of re-hospitalization and decreasing the need for psychiatric hospitalization by implementing consistent community based outpatient treatment strategies. Each regional CMHC has an identified hospital liaison. The two state hospitals have also identified admission/discharge liaisons. The discharge planning process is initiated between the two liaisons upon consumer admission to the state hospital facility. Regular follow up contact is maintained between the liaisons during the inpatient stay, reviewing the consumer's progress and discharge plan needs and goals. As part of the discharge plan, all consumers being discharged from a state hospital are scheduled for a follow up appointment with the regional CMHC within 7 days of discharge from the hospital. This ensures all consumers receive follow up services upon re-entry to their community and assistance with

accessing ongoing community based mental health treatment services as needed.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: The practice of follow-up with consumers within 7 days of discharge from a state hospital is an exemplary practice. DHW adheres to the established "Admission to and Discharge from State Psychiatric Inpatient Facilities" policy implemented in 2000 and places a high priority on providing a system of continuity of care. The implementation of identified hospital liaisons has greatly improved communication and consistent discharge planning between the regions and the state hospitals.

OUTCOME: This objective was NOT ACHIEVED. During FY03 the public mental health system experienced a 15 % increase in total persons served. Additionally, due to a 3.5% budgetary holdback during FY03, 11 full time positions were eliminated in the DHW Adult Mental Health program. Idaho continues to experience a waiting list for committed person to be admitted to the two state hospitals for treatment and stabilization. As a result of these and other factors, the mental health program continues to focus on maximizing limited resources and developing alternative community placements while providing quality services. We will continue to monitor this outcome and identify appropriate service system change should a trend be established for this measure.

Objective 1.7 Indicator Data Table

Objective 1.7	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Community follow-up after state hospital discharge				
Value				
If Rate: **Numerator**: % of persons in FY03 seen by community provider within 7 days of discharge from state hospital **Denominator:** % of persons in FY02 seen by community provider within 7 days of discharge from state hospital	63.2%	59.6%	69.0%	86%

Objective 1.8: **To maintain at the previous fiscal year's level the % of persons discharged from a state hospital that are admitted for inpatient psychiatric care within 30 days.**

Narrative 1.8: ACTIVITIES: DHW places a high priority on reducing the rate of re-hospitalization. Each regional CMHC has an identified hospital liaison. The two state hospitals have also identified admission/discharge liaisons. The discharge planning process is initiated between the two liaisons upon consumer admission to the state hospital facility. Regular follow up contact is maintained between the liaisons during the inpatient stay, reviewing the consumer's progress and discharge plan needs and goals. As part of the discharge plan, all consumers being discharged from a state hospital are scheduled for a follow up appointment with the regional CMHC within 7 days of discharge from the hospital and are scheduled for a medication follow up appointment. Outpatient services are arranged to be provided by the regional CMHC or a private provider. This ensures consumers being discharged from a state hospital will have an opportunity to transition to needed community based mental health treatment, therefore reducing the risk of re-hospitalization.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: DHW is committed to the concept of maintaining consumers in their communities and reducing the rate of re-hospitalizations. DHW adheres to the established "Admission to and Discharge from State Psychiatric Inpatient Facilities" policy implemented in 2000 and places a high priority on providing a system of continuity of care. The implementation of identified hospital liaisons has greatly improved communication and consistent discharge planning between the regions and the state hospitals.

OUTCOME: This objective was NOT ACHIEVED. As reported in the previous objective, the public mental health system in Idaho experienced a decrease in staff, growing waiting lists for state hospital admissions and a 15 % increase in persons served during FY03. Idaho remains committed to reducing the rate of psychiatric re-hospitalization and will continue to identify strategies to meet this goal.

Objective 1.8 Indicator Data Table

Objective 1.8	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Readmission rates following state hospital discharge				
Value				
If Rate:				

Numerator: % of persons readmitted within 30 days of state hospital discharge in FY03 **Denominator:** % of persons readmitted within 30 days of state hospital discharge in FY02	5.5%	8.4%	6.2%	74%

Objective 1.9: **To maintain at the previous fiscal year's level the % of persons discharged from a state hospital who keep their first medication follow up appointment with a physician at their community mental health provider.**

Narrative 1.9: ACTIVITIES: DHW places a high priority on reducing the rate of re-hospitalization and decreasing the need for psychiatric hospitalization. Each regional CMHC has an identified hospital liaison. The two state hospitals have also identified admission/discharge liaisons. The discharge planning process is initiated between the two liaisons upon consumer admission to the state hospital facility. Regular follow up contact is maintained between the liaisons during the inpatient stay, reviewing the consumer's progress and discharge plan needs and goals. As part of the discharge plan, all consumers being discharged from a state hospital are scheduled, prior to being discharged, for a follow up medication appointment with the regional CMHC physician or the consumer's personal physician within two weeks of discharge. This ensures all consumers receive follow up services upon re-entry to their community and access to medication management services.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: The practice of scheduling a medication follow-up appointment within two weeks of discharge from a state hospital is an exemplary practice.

OUTCOME: This objective has been ACHIEVED.

Objective 1.9 Indicator Data Table

Objective 1.9	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Community follow-up with physician				
Value				
If Rate: **Numerator**: % of persons in FY03 who keep their first medication follow-up appointment with a physician **Denominator:** % of persons in FY02 who keep their first medication follow-up appointment with a physician	73.2%	80.3%	76.3%	100%

CRITERION 2

ESTIMATES OF PREVALENCE AND TREATED PREVALENCE OF MENTAL ILLNESS: The plan contains estimates of the incidence and prevalence in the state of SMI and SED and contains quantitative targets to be achieved in the implementation of the mental health system, including the numbers of individuals with SMI and SED to be served (previously Criteria 2 and 11)**.**

GOAL 2: TO INCREASE THE NUMBERS OF PERSONS BEING SERVED BY THE STATE'S PUBLIC MENTAL HEALTH SYSTEM

Objective 2.1: **Keep constant at the rate of FY02 the numbers of persons being served by the public mental health system (Medicaid and non-Medicaid) in FY2003, given the influences of population growth, no significant growth in state funding and major system reconfiguration.**

Narrative 2.1: ACTIVITIES: The identified objective was to maintain the rate of the previous fiscal year of persons being served by the public mental health system. It should be noted that there was a 15% increase in the number served by the public mental health system in FY03.

CHANGES IN IMPLEMENTATION STRATEGIES: The objective of serving 14,173 was based on total persons served client count projections for FY02 which included persons served by private sector MH providers, as that was our method for counting clients at the time. We have since improved our capacity to counts persons served by the public mental health system and are now able to report more accurate numbers for total persons served by the public mental health system. Specifically, we have

enhanced the ability to collect data for non billable clients served by DHW. In the performance indicator chart you will notice an updated count for total served in FY02 which more accurately reflects the stated objective of serving persons in the public mental health system. Based on the updated count our objective should have been to maintain a rate of 12,225 person served by the public mental health system.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was ACHIEVED as the number of persons served during FY03 exceeds the number of persons served in FY02 by 15%.

Objective 2.1 Indicator Data Table

Objective 2.1	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Service penetration				
Value				
If Rate: **Numerator**: Number of adults served in FY03	12,225	14,032	14,173	100%
Denominator: Number of adults served in FY02.				

Objective 2.2 **The Division of Family and Children's Services (FACS) will develop the capacity to gather uniform data to maximize the availability and accessibility of statewide and regional data during FY03.**

Narrative 2.2: ACTIVITIES: In June 2001 the state submitted an application to SAMHSA and was awarded a three-year State Mental Health Data Infrastructure Grant. This grant would assist the state with building the infrastructure needed to report all of the required MHSIP data elements for the Federal Community Mental Health Block Grant Application and Plan. In addition, the improved data system will provide the state with the information it needs to better manage services, as well as to be more accountable to the legislature and other stakeholders.

A Steering Committee and Operations Team were organized to monitor and coordinate the Data Infrastructure Grant (DIG) project. DIG then became part of a larger data project to integrate Developmental Disabilities and Mental Health (DD/MH) data collection into the existing Family Oriented Community User System (FOCUS) used by the Children and Family Services program. This larger DD/MH Integration project was then incorporated into the development of the Care Management

Information System (CAMIS). CAMIS will be a Department wide data system including the Divisions of Family and Community Services, Welfare and Medicaid. The system will also allow the capability to prior authorize Medicaid and non-Medicaid services for the Department.

In order to assure collection of MHSIP data by October, 2003, the Department pursued a contingency plan which was to modify an existing regional mental health data system for statewide implementation. The Integrated Mental Health Program (IMHP) system was modified to collect all of the required MHSIP data elements and was implemented in October 2003. The IMHP data system is intended to be an interim system until the CAMIS system is operational on a statewide basis.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective has been ACHIEVED.

CRITERION 4

TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS: The plan provides for the establishment and implementation of a program of outreach to and services for individuals with SMI or SED who are homeless; and additionally describes the manner in which mental health services will be provided to individuals residing in rural areas (previously Criteria 8 and 10).

GOAL 4: **TO IMPROVE THE ACCESS, QUALITY AND APPROPRIATENESS OF SERVICES PROVIDED TO (A) PERSONS IN IDAHO WHO ARE MENTALLY ILL AND HOMELESS (OR AT RISK OF BECOMING HOMELESS) AND (B) PERSONS LIVING IN RURAL AND FRONTIER AREAS OF THE STATE**

Objective 4.1: **A total of 1250 individuals will be served through Federal PATH grant funds and other sources. Of that total, 900 individuals will be served from direct PATH grant funds in FY2003.**

Narrative 4.1: ACTIVITIES: Idaho receives $300,000 federal PATH Grant funds which are matched with $100,000 state general funds. PATH funds are allocated to each of the seven regional CMHC's of the state with the majority given to regions IV and VI. The reason for the imbalance is based on population and the historical implementation of this homeless program in Idaho. When the Federal homeless program began in Idaho, Regions IV and VI were selected as recipients of the funds with the intent of developing two strong programs. Since that time an increase in the PATH budget was

realized and the additional funds were distributed to each of the remaining five regions.

In Idaho, PATH clients have some of the most disabling mental disorders. Among clients for whom a diagnosis was reported, nearly 43 percent had schizophrenia and other psychotic disorders and 36 percent had affective disorders such as depression. At least 58 percent of the clients had a substance abuse disorder in addition to a serious mental illness.

Among the services eligible for funding under PATH are:

- outreach services,
- screening and diagnostic services,
- habilitation and rehabilitation services,
- community mental health services,
- alcohol or drug treatment services (for people with mental illnesses and co-occurring substance use disorders),
- case management services,
- supervisory services in residential settings and
- a limited set of housing services and services to help clients access housing resources.
- drop-in center supportive services, including partial funding of the facility, staffing and case management

Much of the staff effort is dedicated to helping PATH-eligible clients secure and maintain housing and linking them to treatment services. PATH funds are also used to help the 'near' homeless, those who are discharged from psychiatric hospitals, and those who are at-risk of becoming homeless. Services are directed towards assisting consumers locate housing, learn how to budget and pay their bills, and working with landlords, which often means intervening before eviction takes place, providing or accessing transportation, insuring daily living skills are adequate, and assisting with the acquisition their benefits.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was ACHIEVED.

Objective 4.1 Indicator Data Table

Objective 4.1	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. # of homeless mentally ill receiving services				
Value				

If Rate: **Numerator**: Number of homeless mentally ill served in FY03 **Denominator:** Number of homeless mentally ill served in FY02.	1,313	1,364	1,250	100%

Objective 4.2: **Each regional CMHC will conduct at least one mental illness awareness training with local providers of homeless services by the end of FY2003.**

Narrative 4.2: ACTIVITIES:

- Region 1- Training was completed on April 10, 2003 at the Transitional Housing Center of St. Vincent de Paul which is the local facility for homeless families in Coeur d'Alene. Participants included the Director of Social Services at St. Vincent de Paul and seven staff of the Transitional Housing Center. The topics covered in the trainings were mental illness prevalence treatment and special challenges in regards to housing for persons with a mental illness.
- Region 2- CMHC staff provided two trainings for homeless services providers. The trainings were conducted at YWCA Homeless Shelter on 9-29-03 and at Sojourner's on 9-17-03. The trainings focused on the services provided by the Region II CMHC, the involuntary commitment process and how to handle mental health emergencies with emphasis on accessing the mental health crisis system.
- Region 3- The CMHC has two identified staff who serve as liaisons for the Light House Homeless Shelter and the Salvation Army Shelter. In-service presentations regarding mental illness awareness, how to access mental health services and service availability through the regional CMHC are made every six months at the two facilities. The last presentations were made in April and May 2003.
- Region 4 CMHC participates two times a year in Mental Health Collaborative meetings with Terry Reilly Health Services, St. Luke's Hospital, Intermountain Hospital, Sunhealth and Garden City Community Clinic. During these meetings training on CMHC clinic and mental health services available to homeless persons is provided. The meetings focus on continuity of care between all of the agencies providing homeless services, resource identification and assessing service system strengths and gaps. The meetings are collaborative and help to strength the public and private sector partnership.
- Region 5- In FY03, CMHC staff provided three mental health awareness training opportunities focusing on housing options, grant applications, existing resources, mental health crisis services and crisis beds. Presentations were made to the County Mental Health Task Force

consisting of county commissioners and Welfare Directors, the Idaho Housing Council and the private sector PSR provider agencies.

- Region 6- The CMHC conducted training which covered community resources for the homeless population and risk assessment of the mentally ill on March 4, 2003. The CMHC continues to contract with Aid for Friends, a local homeless shelter, to provide representative payee services for many of the CMHC clients who are incapable of managing their own funds without assistance. As a result, a strong relationship has been established between the CMHC and the homeless shelter resulting in improved access to services and referrals for mental health screenings.
- Region 7- Training was provided on July 8, 2003 to The Haven, a women's and children's homeless shelter, and City of Refuge, the men's homeless shelter. The training was focused on mental health awareness, available services and networking.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: Each regional CMHC has established a relationship with its local providers of homeless services and actively participates in providing community training related to mental illness awareness and service availability. Several programs have established an identified liaison to facilitate consistent communication between the CMHC and homeless services providers. This allows for earlier identification of possible referrals and improved access to services.

OUTCOME: This objective was ACHIEVED.

Objective 4.2 Indicator Data Table

Objective 4.2	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Regional training for providers of homeless mentally ill				
Value				
If Rate: **Numerator**: Number of regional trainings for providers completed / **Denominator:** 7 DHW Regions	10 /	11 /	7 / 7	100%

Objective 4.3: **To provide accessible mental health services to those individuals residing in the rural and frontier counties in Regions VII and I through the use of telemental health services.**

Narrative 4.3:

ACTIVITIES: Region I CMHC has been using telemedicine with their psychiatric consultants for the delivery of pharmacological management services between the Sandpoint office and the office in Bonners Ferry. Currently, there are 30 consumer's receiving telemedicine services in Bonners Ferry with an average of five to ten consumers per month using the service. All telemedicine contacts are monitored, and consumer satisfaction is reported to be high related to eliminating the 45 minute travel time and the need to arrange transportation, decreased time missed from work to attend appointments and decreased need to arrange child care to attend appointments. Consumers who do not like the system are accommodated with face to face appointments in the Sandpoint office. Telemedicine contacts are used for medication follow up appointments only, as all initial psychiatric assessments are conducted in person. The current system is a basic set up consisting of an 8x8 set-top videophone connected through the regular phone line and the use of speaker phones. The system was initially set up with a dedicated phone line but there were problems with sound distortion so there was a change to the regular phone line. Netmeeting was also set up for use on the computer system however the viewable picture was too small and there was a significant voice delay. After several trials it was decided to resume the use of the set top videophone system. The program is continuing to evaluate options for upgrading its system.

Region 7 CMHC also is using the VIA TV set top videophone system. The system is used between the regional CMHC office in Idaho Falls where the physician is located and the field office in Salmon. A total of 57 consumers participated in telemental health services during FY03. The service is used only for ongoing medication management services. All initial appointments with the physician are conducted face to face.

CHANGES IN IMPLEMENTATION STRATEGIES: None identified.

INNOVATIVE/EXEMPLARY MODELS: The use of telemental health services has improved access to psychiatric services for consumers living in the more rural areas in the state. This technology will continue to be evaluated for further implementation.

OUTCOME: This objective was ACHIEVED.

Objective 4.3 Indicator Data Table

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: **3.** Telemental health services				
Value		1.4%		

If rate: **Numerator:** Number of consumers receiving telemental health services in FY03 **Denominator:** Total number of consumers receiving services in FY 03 (Reg. 1 & 7)	NA	87 6262	87	100%

Objective 4.4: **The State Planning Council on Mental Health will appoint a representative from the Hispanic community to the Council by the end of FY 03.**

Narrative 4.4: ACTIVITIES: The State Planning Council on Mental Health identified a potential representative from the Hispanic community and recommended they be appointed to the Council. Attempts were made by the then Chair of the Council for the identified individual to join the Council, however this was not successful. At present, the Council has been unable to appoint a representative from the Hispanic community to the Council. The Council will continue its efforts to gain representation from the Hispanic Community

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was NOT ACHIEVED as explained in the narrative.

Objective 4.5: **The Bureau of Mental Health and Substance Abuse will continue to consult with the Division of Health regarding maximizing statewide participation in the Health Professionals Shortage Area program during FY 03.**

Narrative 4.5: ACTIVITIES: The Division of Health is the agency responsible for coordinating Health Professional Shortage Area (HPSA) designation for the State. This designation is made on a regional basis. The Division of Health representative regularly provides updated information on regional application status and approval notices to the Adult Mental Health program specialist. Consultation between the two programs occurs on an as needed basis to discuss changes in application status and provide information and education on both programs. Application and approval status is monitored regularly in order to maximize the state's participation in the HPSA program related to mental health service providers.

Currently, Regions 1 and 5 continue to maintain HPSA designation. HPSA designation for Regions 3 was changed from a population designation to a geographic designation during FY03, and Region 4 was awarded a geographic designation for the first time. Applications for Region 2, 6 and 7 are currently pending and in the process of being completed.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective has been ACHIEVED.

CRITERION 5

MANAGEMENT SYSTEMS: The plan contains a description of the financial resources, staffing and training necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training of providers of emergency health services regarding mental health. Also, the plan describes the manner in which the state intends to expend the grant for the fiscal year involved to carry out the provisions of the plan (previously Criteria 5 and 12).

GOAL 5: THE STATE WILL CONTINUE TO USE THE FEDERAL MENTAL HEALTH BLOCK GRANT AS AN OPPORTUNITY TO DEVELOP AND FUND INNOVATIVE PROJECTS, AS WELL AS PROVIDING ADEQUATE FUNDS FROM OTHER NON-FEDERAL SOURCES TO PROVIDE ACCESSIBLE, HIGH QUALITY AND APPROPRIATE MENTAL HEALTH SERVICES TO THE TARGET POPULATION, AND WILL PROVIDE TRAINING TO MENTAL HEALTH SERVICE PROVIDERS AND OTHER SPECIALIZED GROUPS.

Objective 5.1: Financial and programmatic reports on the use of FY03 Federal CMHBG funds (including outcomes) will be presented to the State Planning Council on Mental Health at each of their meetings in FY03.

Narrative 5.1: ACTIVITIES: A presentation on the FY03 Federal CMHBG was made at each of the State Planning Council meetings. Meetings were held January, April and August 2003. During the January meeting the approved plan and budget were distributed and reviewed. The plan and budget were again reviewed during the April meeting as the budget was adjusted to the increased award amount. During the August meeting the new application, plan and updated budget was presented to the Council for their review and approval.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: The State Planning Council places a high priority on its role in monitoring the distribution of the Federal Community MH Block Grant funds. DHW values the input of the Council and makes every attempt possible to incorporate the Council's recommendations related to the Block Grant funds.

OUTCOME: This objective has been ACHIEVED.

Objective 5.1 Indicator Data Table

Objective 5.1	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. CMHBG report to State Planning Council				
Value				
If Rate: **Numerator**: Number of reports made in FY03 **Denominator:** 3 meetings	3 /	3 /	3 / 3	100%

Objective 5.2: **In FY2003 the Bureau of Mental Health and Substance Abuse, in consultation with the regional CMHC's, will write and adopt a statewide training plan for public mental health service providers. This plan will include addressing the training needs of law enforcement and emergency medical service providers.**

Narrative 5.2: ACTIVITIES: The Family and Community Services (FACS) Division's Adult Mental Health Program and the Planning, Evaluation and Training unit worked jointly in a series of meetings to develop a draft training plan for the Adult Mental Health Program. The draft training plan is based on the FACS Division training plan in an effort to be consistent with the Division's and the Department's strategic plans and goals. Specific mental health program training needs and priorities will continue to be identified and incorporated into the training plan as development of the mental health program standards and competencies continues. Additionally, the regional mental health program managers were asked to identify their staff's top three training needs which will be incorporated into the program training plan.

CHANGES IN IMPLEMENTATION STRATEGIES: The training plan is considered to be in draft format as work continues to take place towards developing program standards and identifying competencies and related training needs. It is our intention to have the training plan adjust and change based on the identification of these training needs. The plan will

assist the program in the ongoing identification and prioritization of training needs.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective has been ACHIEVED.

Objective 5.3: **The Bureau of Mental Health and Substance Abuse will provide no less than one statewide training opportunity for cross training of staff providing services to persons with a dual diagnosis of mental illness and substance abuse in FY2003.**

Narrative 5.3: ACTIVITIES: The Division of Family and Community Services Adult Mental Health Program provided funding for the seven regional CMHC's to send a total of 23 staff and 2 central office staff to attend the Annual Idaho Conference on Alcohol and Drug Dependency. The conference was held in Boise, Idaho on May 12-15, 2003. Funding was provided for the cost of registrations ($4580), travel and lodging.

CHANGES IN IMPLEMENTATION STRATEGIES: None

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective was ACHIEVED.

Objective 5.3 Indicator Data Table

Objective 5.3	**FY 2002 Actual**	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 1. Training on dual diagnosis disorders				
Value: Number of training opportunities completed in FY03	1	1	1	100%
If Rate: **Numerator**: **Denominator:**				

Objective 5.4: **To minimize the impact of state budget reductions on direct clinical services by allocating funds to the seven regional mental health centers to support their personnel budgets for direct clinical service positions during FY2003.**

Narrative 5.4: ACTIVITIES: $291,315 has been allocated out of the Federal Community Mental Health Block Grant to fund staff positions in the regional programs. The funds have been allocated to the regional program budgets to support personnel, which allows Idaho to supplement seven positions in the adult CMHC program statewide. Without this allocation the program would be required to eliminate the positions. Idaho remains committed to providing a quality community based system of care for adults with a serious and persistent mental illness. This distribution of CMHS Block Grant funds continues to allow Idaho to enhance its Adult Community Mental Health Program by supplementing staffing resources and service delivery capability.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective has been ACHIEVED.

Objective 5.4 Indicator Data Table

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 4. Regional budgets to support personnel				
Value: Total funds allocated to the regional budgets to support personnel	N/A	$291,315	$291,315	100%
If rate: **Numerator:** **Denominator:**				

Objective 5.5: The Bureau of Mental Health and Substance Abuse will continue to provide financial support for family member and consumer coordination services during FY2003.

Narrative 5.5: ACTIVITIES: The Adult Mental Health Program has contracted with Mountain States Group for the provision of an Office of Consumer Affairs and Technical Assistance. The contract requires the Office of Consumer Affairs to provide statewide consumer education and coordination services, advocacy training and technical assistance for adults with severe and persistent mental illness. A second contract is with NAMI, Idaho for the provision of information, support, technical assistance, training and

coordination of self-help efforts of family members of adults with serious mental illness.

CHANGES IN IMPLEMENTATION STRATEGIES: No changes.

INNOVATIVE/EXEMPLARY MODELS: None identified.

OUTCOME: This objective has been ACHIEVED.

Objective 5.5 Indicator Data Table

	FY 2002 Actual	**FY 2003 Actual**	**FY 2003 Objective**	**% Attainment**
Performance Indicator: 5. Consumer Coordination/ Family Support				
Value: Total funds allocated to support family member and consumer coordination services	$120,000	$132,000	$132,000	100%
If rate: **Numerator:** **Denominator:**				

Additional Requested GPRA Measures for Adults with Serious Mental Illness

	FY 2001 Actual	**FY 2002 Actual**	**FY 2003 Actual**
Performance Indicator: Percent of clients employed six months after admission to non-institutional services.			
Value			
If Rate: **Numerator**: Number of clients employed six months after admission to non-institutional services FY03 **Denominator:** Number of clients receiving PSR services in FY03.	N/A	N/A	N/A

	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual
Performance Indicator: 1. Percent of clients who are living independently.		40%	73%
Value			
If Rate: **Numerator**: Number of PSR clients living independently FY03 **Denominator:** Number of completed Baseline Surveys	N/A	860 2173	1423 1952

	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual
Performance Indicator: Percent of clients who have been arrested in the last year.		5%	10%
Value			
If Rate: **Numerator**: Number of PSR clients arrested in FY03 **Denominator:** Number of completed Baseline Surveys	N/A	101 2173	188 1952

SECTION V

State Level Data Reporting Capacity Checklist - FY2003 State Reports

Revised

June 2003

State Level Data Reporting Capacity Checklist - FY2002 State Reports

Please complete the following form indicating the capacity of the State Mental Health Authority to report the following data elements.

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Age	No				Yes	2004
Gender	**No**				**Yes**	2004
Race/Ethnicity Categories						
New Federal Race and Hispanic Origin Categories are Used in Community Settings	No				**Yes**	2004
New Federal Race and Hispanic Origin Categories are Used in State Hospitals	No				**Yes**	2004
Living Situation Categories						
" Homeless Status of Persons Served in the Community	No				**Yes**	2004
" Persons Served - State psychiatric hospitals	No				**Yes**	2004

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
" Persons Served - Other psychiatric hospitals	No				**Yes**	2004
Employment Status Categories						
" Full time or part time Competitive Employment	No				**Yes**	2004
" Unemployed	No				**Yes**	2004
- Not in Labor Force	No				**Yes**	2004

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES, Using Federal CMHS definitions/ categories? (Yes/No)	IF NO, Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Patient Funding Support Categories						
" Persons Served Through Medicaid Only	No				**Yes**	2004
– Persons Served Through Other Funding Sources Only	No				**Yes**	2004
" Persons Served by Both Medicaid and Non-Medicaid Sources	No				**Yes**	2004
Client Turnover Status Categories						
" State Hospitals - Admissions	No				**Yes**	2004
" State Hospital " Discharges	No				**Yes**	2004
" State Hospital " Average length of service (ALOS) (discharges)	No				**Yes**	2004
-- State Hospital " ALOS (residents	No				**Yes**	2004

at end of year)						
" Other Inpatient Settings - Admissions	No				**Yes**	2004
" Other Inpatient Settings – Discharges	No				**Yes**	2004
– Other Inpatient Settings - ALOS (discharges)	No				**No**	2004
– Other Inpatient Settings - ALOS (residents at end of year)	No				**No**	2004

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES, Using Federal CMHS definitions/ categories? (Yes/No)	IF NO, Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Block Grant Non-Direct Service Expenditure Categories						
– Technical Assistance	No				**Yes**	2004
" Planning Council	No				**Yes**	2004
" Administration	No				**Yes**	2004
" Data collection/ reporting	No				**Yes**	2004

" Other Activities	no				**Yes**	2004
Dual Diagnosis Status Categories						
Adults Served Who Had a Diagnosis of Substance Abuse and MH	no				**Yes**	2004
Adults with SMI Served Who Had a Diagnosis of SA and MH	No				**Yes**	2004
Children Served Who Had a Diagnosis of SA and MH	No				**Yes**	2004
Children with SED Served Who Had a Diagnosis of SA and MH	No				**Yes**	2004

State Level Data Reporting Capacity Checklist - Developmental Tables

Please complete the following form indicating the capacity of the State Mental Health Authority to report the following data elements.

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Operational Definition to	No				**Yes**	2004

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Identify Adults with SMI						
Operational Definition to Identify Children with SED	No				**Yes**	2004
Living arrangement - Living in Private Residence	No				**Yes**	2004
Living arrangement- Living in Foster Care	No				**Yes**	2004
Living arrangement - other 24-hr residential	No				**Yes**	2004
Evidence-Based Practices						
Supported Housing Services	No				**Yes**	2004
Supported Employment Services	No				**Yes**	2004
Assertive Community Treatment (ACT) programs	No				**Yes**	2004
New Generation Medications: in State Hospitals	No				**Yes**	2004

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
New Generation Medications in Community Settings	No				**Yes**	2004
Integrated Treatment for Persons with Mental Illness and Substance Abuse	No				**Yes**	2004
Therapeutic foster care	No				**Yes**	2004
Family PsychoEducation	No				**Yes**	2004
Illness Management and Recovery Skills	No				**Yes**	2004
Outcome Measures						
School attendance - Children"s	No				Yes	2004
Criminal justice involvement - Adults	No				Yes	2004
Criminal justice involvement - Children	No				Yes	2004
School Performance – Children	No				Yes	2004

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)